Group Insurance Commission
Commonwealth of Massachusetts

Dental Benefits Plan

DELTA DENTAL®

Delta Dental Plan of Massachusetts

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Welcome

We are pleased to be providing dental benefits to you and other Commonwealth of Massachusetts Employees through the GIC.

Two different dental benefits programs are offered to GIC members, and you need to know which plan you have chosen — the Dental PPO or the Dental Indemnity Plan — before using your benefits. Both of these programs are explained in detail in the pages that follow, along with information on how to use each plan.

We hope you'll take a few minutes to read through this benefit booklet so that you'll know how to get the most value out of your Delta Dental Plan program. Be sure to read about the particular plan you are enrolled in. If you are unsure of which program you subscribe to, please call (800) 553-6277 and one of our Customer Service Representatives will assist you.

Remember, your dental care is an important part of your overall health care. We encourage you to take advantage of the generous benefits offered in this program and get the quality dental care you need to maintain good oral health.

Please save this booklet and refer to it for information on your plan. If you have any questions regarding your benefits or how to use your plan, please feel free to contact us at (800) 553-6277. Our Customer Service Representatives are happy to assist you.

Who to Call

Call Delta Dental Plan of Massachusetts at (800) 553-6277 or visit our Web site www.deltamass.com if…

- You need to replace your identification card
- You want to verify a dentist's participation in the Dental PPO (DeltaPreferred Option) network
- You want to verify a dentist's participation in the Dental Indemnity Plan (DeltaPremier USA) network
- You have a question about your dental benefits, a claim, or an Explanation of Benefits (EOB)
- You are concerned about the treatment you are receiving from a participating network dentist

Call the GIC at (617) 727-2310 ext. 801 if…

- You have a question about enrollment or eligibility
- You need information about COBRA

Contact the GIC Coordinator at your workplace if…

- You change your address
- You need a Student Verification Form

Enrollment & Eligibility

Am I eligible for benefits?

You are eligible for dental benefits if you:

- work for the Commonwealth
- are eligible for life and/or health benefits through the GIC
- are not otherwise eligible for dental benefits through a separate appropriation or the provisions of a contract or collective bargaining agreement
- are not eligible for dental benefits provided in whole or in part through employer-provided funding

You are not eligible for dental benefits if you are employed by an Authority.

How do I pay for the plan?

The premiums for the dental plan cover both your dental and your vision benefits. To receive these benefits, you must pay a monthly premium, which will be deducted directly from your paycheck. In addition, you may be responsible for member co-payments and any non-covered benefits when you visit a dental office.

Can I change my plan?

You cannot change your plan until the next GIC annual enrollment, even if your dentist withdraws from the network. If your dentist withdraws from the network, Delta Dental will be happy to provide names of other participating dentists in your area.

What if I choose to withdraw from the plan?

You may withdraw from the plan at any time by contacting the GIC Coordinator at your worksite. However, if you withdraw from the plan at any time during the year, you will be ineligible for re-enrollment in the plan until the July 1st following 24 months from the date coverage ended.

If coverage is terminated or cancelled for non-payment of premium, you will be ineligible for re-enrollment in the plan until the July 1st following 24 months from the date coverage ended.

Can I enroll my family in the dental plan?

You can elect family coverage for the dental plan, and you can enroll: (1) your legal spouse; (2) unmarried, dependent children under the age of 19; (3) the children of unmarried eligible dependents; and (4) divorced spouses may also be eligible for coverage under certain conditions.

Married children are not eligible. Unmarried dependent children's coverage will terminate on the last day of the month in which they reach age 19. However, there are three exceptions — all of which need to be approved by the GIC.

1. Full-time students are eligible for coverage until the last day of the month in which they reach age 24. (Eligible students age 24 and over may remain on the plan; however, they must pay the full cost of the monthly premium.) Unless the student is enrolled in a health plan sponsored by the GIC, you must confirm your child's full-time student status each semester by submitting a Student Verification Form directly to the GIC. See your GIC Coordinator for a Student Verification Form. Failure to submit the required verification will result in denial of student dependent claims.

2. Handicapped dependents whose Handicapped Dependent Application has been approved by the GIC are eligible for coverage. Contact the GIC for a Handicapped Dependent Application Form.

3. Where a husband and wife are employed by the Commonwealth and both are eligible for coverage in the GIC Dental Plan, they may each have individual coverage, or alternatively, one may have family coverage that will cover the other as a dependent.

If you have questions about your eligibility or your dependents, please call the GIC.

What if my family also has coverage with another plan?

If you, your spouse, or any of your eligible dependents are covered by more than one dental plan (or a medical plan that offers dental coverage), you must notify Delta Dental Plan and we will coordinate benefits with the other carrier(s). In determining coverage, total payments from both carriers cannot exceed the allowable charge for the service.

When will my benefits stop?

Your benefits will continue as long as you meet the eligibility requirements outlined on page 4 unless you choose to withdraw from the plan or fail to pay your monthly premiums. If you fail to meet the eligibility requirements, your coverage will end on the last day of the month following the month in which you cease to be eligible provided that your premium is paid to date.

Can I continue my benefits even if I become ineligible?

The federal COBRA law enables you and your family to receive temporary dental benefits from the GIC under certain circumstances, which are referred to as "qualifying events." The benefits you and your family receive with COBRA will be the same benefits enjoyed by active plan members. However, you and your family will be responsible for 102% of the premium.

Who is eligible for COBRA benefits?

Qualifying Events	*Who's Eligible*	*Extended Coverage**
Employee termination (for reasons other than gross misconduct)	Employee, spouse, and dependents	18 months
Work hours reduced	Employee, spouse, and dependents	18 months
Employee death	Surviving spouse and dependents	36 months
Employee divorce or legal separation	Divorced or legally separated spouse and dependents	36 months or until the marriage of ex-spouse whichever is earlier
Employee becomes eligible for Medicare	Spouse or dependents not eligible for Medicare	36 months
Dependent child older than age maximum	Dependent children who are older than the age maximum	36 months

* If a second qualifying event occurs during the COBRA coverage period, you, your spouse, or your dependents are entitled to continue coverage for an additional period of up to a maximum of 36 months from the beginning of the first qualifying event.

Does COBRA coverage ever get cancelled?

You, your spouse, or your dependents will lose COBRA coverage if:

- You, your spouse, or your dependents become covered under any other group dental plan that does not contain any exclusion or limitation with respect to pre-existing conditions.
- You, your spouse, or your dependents fail to promptly pay your monthly COBRA premium.
- The GIC no longer provides dental benefits.

How do I apply for COBRA benefit coverage?

You or your agency must notify the GIC within 30 days of your qualifying event. Once the GIC receives this information, we will mail you a letter notifying you of your COBRA rights as well as an application. If you do not receive a notification letter and believe you are eligible for COBRA coverage, call the GIC immediately — if you do not apply for the COBRA coverage within 60 days of the date the GIC sends the notification letter, you will lose your COBRA eligibility. (Remember, it is your responsibility to make sure an accurate address is on file with the GIC.)

You, your spouse, or your dependents must notify the GIC in the event of a divorce, remarriage, or a change in dependent status. Once notified, the GIC will send a letter asking if you, your spouse, or your dependents wish to purchase COBRA coverage. Keep in mind, your spouse and your dependents will lose their COBRA eligibility if the GIC is not notified within 60 days of the date, of the divorce, the remarriage, or the change in dependent status; or the date coverage terminated under the plan as the result of the qualifying event changes.

This information should be used only as a guideline for COBRA coverage and your rights under COBRA law. If you have questions regarding your eligibility for COBRA coverage, please contact the GIC.

Dental Indemnity Plan

[DeltaPremier USA]

The Dental Indemnity Plan, which is also referred to as DeltaPremier USA, offers coverage through an extensive network of dentists — 95% of Massachusetts dentists participate in our DeltaPremier program. And as a member of DeltaPremier USA, you have access to more than 107,000 dentists across the country. You will receive a higher benefit level when you receive care from a network dentist, and your dentist will take care of your claims for you.

Will I get an identification card?

Two identification cards will be mailed to your home shortly after your enrollment. Both cards will be issued in the employee's name, but they can also be used by your spouse and covered dependents.

Do I need to visit a network dentist?

While you are not required to receive dental care from a network dentist, you will maximize your benefits when you visit one of the plan's dentists. In addition, you will enjoy:

- Lower out-of-pocket costs — because most network dentists accept discounted fees for services, you will normally pay less when you visit a participating dentist.
- No claims processing — network dentists will prepare and submit claims for you.
- Direct payment — Delta Dental pays the dentist directly, so you don't have to pay the covered amount up front and wait for a reimbursement check.

To find out if your dentist is part of the DeltaPremier USA network, simply ask your dentist, contact Delta Dental, or visit our Web site.

How does the plan work when I visit a network dentist?

The DeltaPremier USA plan is easy to use. Simply present your ID card to the network dentist during your visit and the dentist will prepare and submit your claim form to Delta Dental for you. Once the claim is processed, you will receive an Explanation of Benefits (EOB) explaining how much we paid the dentist based on your plan's coverage and any remaining balance, which you will pay directly to the provider.

What happens if I receive a treatment that is not covered?

If you receive a treatment that is not covered by your dental plan, you may be billed at the dentist's normal rate rather than Delta Dental's negotiated rate. Be sure to check the list of covered services before receiving any treatment.

What happens when I reach my annual maximum?

Once you meet your annual maximum, you may be billed at the dentist's normal rate rather than Delta Dental's negotiated rate.

What benefits will I receive if I visit a non-participating dentist?

Your dental plan provides coverage for care received from dentists who do not participate in the DeltaPremier USA network, however, you may incur higher out-of-pocket costs than you would if you visited a network dentist.

Delta Dental's payment for services received from non-participating dentists is based on either the dentist's fee or the maximum plan allowance for non-participating dentists, whichever is lower.

If you utilize the services of a non-participating dentist whose fees are higher than the allowable fees, you will be responsible for the difference between Delta Dental's benefit payment and the amount your dentist charges.

How do I file a claim if I visit a non-participating dentist?

When you visit a non-participating dentist you must complete and submit a claim form. If you need a claim form, call Delta Dental Plan or visit our Web site. Once the claim is processed, the payment will be sent directly to you accompanied by an Explanation of Benefits (EOB) that explains the benefit payment. Please remember that non-participating dentists may require you to pay for services at the time of treatment.

How can I avoid unexpected dental costs?

There are a number of ways you can protect yourself from unexpected dental costs. We encourage you to:

- Confirm that the dentist you have selected still participates in the DeltaPremier USA network by calling the dentist's office or Delta Dental or visiting our Web site.
- Have your dentist submit a pretreatment estimate to us for any treatment that you consider costly. Delta Dental will send you an estimate of the benefit payment you will most likely receive for the treatment, which will help you estimate your out-of-pocket costs. (Delta Dental's estimate of the benefit payment is based on the status of your benefits when the pre-treatment estimate is processed — it is not a guarantee of payment.)

Dental Indemnity Plan

[DeltaPremier USA]

This chart represents your coverage, as well as any limitations, for services preformed by dentists who participate in the DeltaPremier USA network — 95% of all Massachusetts dentists participate in our DeltaPremier program. For information about coverage for services provided by non-participating dentists, please see page 9.

Type I Preventive

Deductible: None
Covers 100% of the maximum plan allowance

Diagnostic:	Initial Oral Exam	*Once per visit*
	Periodic Oral Exams	*Twice per calendar year*
	Full Mouth X-rays	*Once per five years*
	Bitewing X-rays	*Twice per calendar year*
	Single Tooth X-rays	*As needed*
	Sealants	*Unrestored permanent molars, once every 48 months under age 14*
Preventive:	Teeth Cleaning	*Twice per calendar year*
	Fluoride Treatments	*Twice per calendar year for members under age 19*
	Study Models & Casts	*Once every 60 months*
	Space Maintainers	*For members under age 19*

Type II Restorative

Deductible: None
Covers 80% of the maximum plan allowance

Restorative:	Silver Fillings	*Once every 12 months per surface per tooth*
	White Fillings	*Once every 12 months per surface per tooth on front teeth; single surface only on back teeth*
	Temporary Fillings	*Once per tooth*
	Stainless Steel Crowns *(baby teeth only)*	*Once every 24 months per tooth*
Oral Surgery:	*Oral surgery benefits not provided when rendered in a surgical day care or hospital setting*	
	Simple Extractions	
	Surgical Extractions	
Periodontics:	Periodontal Surgery *Periodontic benefits not provided when rendered in a surgical day care or hospital setting*	
	Scaling (Full Mouth)	*Once per calendar year*
	Periodontal Cleaning	*Once every 3 months following active periodontal treatment. A maximum of 4 routine/periodontal cleanings per year.*
Endodontics:	Root Canal Treatment	*Once per tooth*
	Pulpotomy	*To age 14*
Prosthetic Maintenance:	Bridge or Denture Repair	*Once within 12 months, same repair*
	Rebase of Reline of Dentures	*Once within 36 months*
	Recement of Crowns and Onlays	*Once within 12 months per tooth*
Emergency Dental Care:	Minor Treatment for Pain Relief	*Three occurrences in 6 months*
	General Anesthesia	*Allowed with covered surgical services only*

Type III Major Restorative

Deductible: None
Covers 50% of the maximum plan allowance

Prosthodontics:	Dentures	Once within 60 months
	Fixed Bridges and Crowns (when part of a bridge)	Once within 60 months
Major Restorative:	Crowns (when teeth cannot be restored with regular fillings)	Once within 60 months per tooth
Calendar Year Maximum:	$1,000 Per Person Per Calendar Year	

Dependents covered up to age 19. Full time students covered to age 24.
Orthodontia: Covered to any age at 50% of the maximum plan allowance with a $1,250 lifetime maximum.

Dental PPO

[DeltaPreferred Option]

The Dental PPO, which is also referred to as DeltaPreferred Option, offers additional claim savings over the Dental Indemnity Plan. You will have lower out-of-pocket costs when you receive care from one of the more than 1,000 dentists that participate in the plan's network. It is also easy to use — your dentist will complete and submit your claim forms for you.

Will I get an identification card?

Two identification cards will be mailed to your home shortly after your enrollment. Both cards will be issued in the employee's name, but they can also be used by your covered spouse and covered dependents.

Do I need to visit a network dentist?

While you are not required to receive dental care from a network dentist, you will maximize your benefits when you visit one of the plan's more than 1,000 dentists. In addition, you will enjoy:

- Low out-of-pocket costs — network dentists accept discounted fees from PPO members, and your co-payments will be based on the discounted fee.
- No claims processing — network dentists will prepare and submit claims for you.
- Direct payment — Delta Dental pays the dentist directly, so you don't have to pay the covered amount up front and wait for a reimbursement check.

How do I know if a dentist is a part of the network?

To find out if the dentist you have selected is part of the DeltaPreferred Option network, contact Delta Dental or visit our Web site.

How does the plan work when I visit a network dentist?

The DeltaPreferred Option plan is easy to use. Simply present your ID card to the network dentist during your visit. The dentist will prepare and submit your claim form to Delta Dental for you. Once the claim is processed, you will receive an Explanation of Benefits (EOB) explaining how much we paid the dentist based on your plan's coverage and any remaining balance, which you will pay directly to the dentist.

What happens if I receive a treatment that is not covered?

If you receive a treatment that is not covered by your dental plan, you may be billed at the dentist's normal rate rather than Delta Dental's negotiated network rate. Be sure to check the list of covered services before receiving any treatment.

What happens when I reach my annual maximum?

Once you meet your annual maximum, you may be billed at the dentist's normal rate rather than Delta Dental's negotiated rate.

What benefits will I receive if I visit a non-participating dentist?

Your dental plan provides coverage for dentists who do not participate in the DeltaPreferred Option network, however, you will incur higher out-of-pocket costs than you would if you visited a network dentist. Benefit payments for non-participating dentists are based on either the dentist's fee or the following — whichever is lower:

- For dentists located outside of Massachusetts, Delta Dental provides coverage up to the maximum plan allowance for the geographic area.
- For Massachusetts dentists, non-participating benefits are subject to a separate $100 per-member annual deductible that applies to all services. Diagnostic services (Type I) are covered at 80%; Basic Restorative services (Type II) are covered at 60%; and Major Restorative services (Type III) are covered at 50%. Non-participating reimbursement is based on either the dentist's charge or the maximum plan allowance for the service — whichever is lower.

If you utilize the services of a non-participating dentist whose fees are higher than the maximum plan allowance, you will be responsible for the difference between Delta Dental's benefit payment and the amount your dentist charges.

How do I file a claim if I visit a non-participating dentist?

When you visit a non-participating dentist you must complete and submit a claim form. If you need a claim form, simply call Delta Dental Plan or visit our Web site. Once your claim is processed, the payment will be sent directly to you accompanied by an Explanation of Benefits (EOB) that explains the benefit payment. Please remember that non-participating dentists may require you to pay for services at the time of treatment.

How can I avoid unexpected dental costs?

There are a number of ways you can protect yourself from unexpected dental costs. We encourage you to:

- Confirm that the dentist you have selected still participates in the DeltaPreferred Option network by calling the dentist's office or Delta Dental, or visiting our Web site.
- Have your dentist submit a pretreatment estimate to us for any treatment that you consider costly. Delta Dental will send you an estimate of the benefit payment you will most likely receive for the treatment, which will help you estimate your out-of-pocket costs. (Delta Dental's estimate of the benefit payment will be based on the status of your benefits when the pre-treatment estimate is processed — it is not a guarantee of payment.)

Dental PPO

[DeltaPreferred Option]

This chart represents your coverage, as well as any limitations, for services performed by dentists who participate in the DeltaPreferred Option network. For information about coverage for services provided by non-participating dentists, please see page 15.

Type I Preventive

Deductible: None
Covers 100% of discounted rates

Diagnostic:	Initial Oral Exam	*Once per dentist*
	Periodic Oral Exams	*Twice per calendar year*
	Full Mouth X-rays	*Once every five years*
	Bitewing X-rays	*Twice per calendar year*
	Single Tooth X-rays	*As needed*
	Sealants	*Unrestored permanent molars, once every 48 months under age 14*
Preventive:	Teeth Cleaning	*Twice per calendar year*
	Fluoride Treatments	*Twice per calendar year for members under age 19*
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Type II Restorative

Deductible: None
Covers 80% of discounted rates

Restorative:	Silver Fillings	*Once every 12 months per surface per tooth*
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	Temporary Fillings	*Once per tooth*
	Stainless Steel Crowns (baby teeth only)	*Once every 24 months per tooth*
Oral Surgery:	*Oral surgery benefits not provided when rendered in a surgical day care or hospital setting*	
	Simple Extractions	
	Surgical Extractions	
Periodontics:	Periodontal Surgery *Periodontic benefits not provided when rendered in a surgical day care or hospital setting*	
	Scaling (Full Mouth)	*Once per calendar year*
	Periodontal Cleaning	*Once every 3 months following active periodontal treatment. A maximum of 4 routine/periodontal cleanings per year.*
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Emergency Dental Care:	Minor Treatment for Pain Relief	*Three occurrences in 6 months*
	General Anesthesia	*Allowed with covered surgical services only*

Type III Major Restorative

Deductible: None
Covers 50% of discounted rates

Prosthodontics:	Dentures	*Once within 60 months*
	Fixed Bridges and Crowns (when part of a bridge)	*Once within 60 months*
Major Restorative:	Crowns (when teeth cannot be restored with regular fillings)	*Once within 60 months per tooth*
Calendar Year Maximum:	$1,000 Per Person Per Calendar Year	

Dependents covered up to age 19. Full time students covered to age 24.
Orthodontia: Covered to any age at 50% of the maximum plan allowance with a $1,250 lifetime maximum.

MORE ABOUT YOUR DENTAL PLAN

More About Claims

- All claims must be submitted within one year of the date of service.
- Under the GIC plans' subrogation clause, you may be required to reimburse Delta Dental for claim payments if you also receive a payment from a third party who is held liable for an injury that required the dental care.
- If a claim is denied, you can request an appeal by writing to Delta Dental within 180 days of receiving notice on the claim.

Limitations and Exclusions

Your dental plan provides benefits for any covered service that is necessary and appropriate, as determined by Delta Dental Plan of Massachusetts. Keep in mind, that benefits are considered only for the services listed in this booklet — if a service is not listed here, you are not eligible for benefits for that service.

Your dental plan will not provide benefits for:

- dental treatment that is primarily for cosmetic purposes;
- dental treatment for which an alternate course of treatment is recommended based on materials and methods of treatment that cost the least and that meet generally accepted

dental standards. You may be reimbursed only the benefit allowed on the procedures specified under this alternate course of treatment;

- treatment performed by anyone other than a duly licensed dentist, except for scalings or cleanings of teeth performed by a licensed dental hygienist under the supervision of a licensed dentist;
- treatment for temporomandibular joint (TMJ) syndrome;
- dental treatment that began before the member's coverage became effective or for dental treatment that continues after the member's coverage ends (multi-visit procedures may be considered on an individual basis — please have your dentist submit a pretreatment estimate before having the service completed);
- a dentist's charge to you for any appointment that you miss;
- dental treatment performed in a hospital owned and operated by the United States Government, or performed elsewhere at the expense of the U.S. Government;
- any dental services and supplies for which a charge would not have been made in the absence of dental coverage;
- dental expenses for an injury for which you recover all or part from a third party who is liable for the injury; or
- all claims for benefits not submitted within one year of the date services were rendered.

Member Rights and Responsibilities

As a Delta Dental member, you have the right to:

- be provided with appropriate information about Delta Dental and its benefits, providers, and policies.
- be informed of your diagnosis, the proposed treatment, and prognosis by your dentist.
- give informed consent before beginning any dental treatment and be made aware of the consequences of refusing treatment,
- obtain a copy of your dental record, in accordance with the law.
- be treated with respect and have your dignity and need for privacy recognized.

You have the responsibility to:

- ask questions in order to understand your dental condition and treatment, and follow instructions for recommended treatment given by providers.
- provide dentists with the information necessary to care for you.
- be familiar with Delta Dental benefits, policies and procedures by reading Delta Dental's written materials or calling the Customer Service department at (800) 553-6277

Group Insurance Commission
Commonwealth of Massachusetts

Benefits Effective July 1, 2002

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